

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0027359</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>SENIOR MANOR NURSING CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>223 EAST FOURTH STREET</u> <u>SPARTA</u> <u>62286</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>RANDOLPH</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>ROGER W. BAGLEY</u> (Title) <u>CONTROLLER</u>	
Telephone Number: <u>(618)443-4411</u> Fax # <u>(618)443-2212</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()	
IDPA ID Number: <u>371119667001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>10/01/82</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>ROGER BAGLEY</u> Telephone Number: <u>(618)549-8331</u> <u>JAMESTOWN MGMT CORP</u>			

Facility Name & ID Number SENIOR MANOR NURSING CENTER# 0027359 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>20</u>	Skilled (SNF)	<u>20</u>	<u>7,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>39</u>	Intermediate (ICF)	<u>39</u>	<u>14,235</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>59</u>	TOTALS	<u>59</u>	<u>21,535</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,887</u>	<u>1,680</u>	<u>359</u>	<u>3,926</u>	8
9	SNF/PED					9
10	ICF	<u>7,709</u>	<u>1,941</u>		<u>9,650</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,596</u>	<u>3,621</u>	<u>359</u>	<u>13,576</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 63.04%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 10/01/70

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 359Medicare Intermediary ADMINSTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/01 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number SENIOR MANOR NURSING CENTER

0027359

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	81,699	4,142	4,492	90,333		90,333		90,333			1
2	Food Purchase		43,556		43,556	1,532	45,088	(130)	44,958			2
3	Housekeeping	38,350	5,169		43,519	81	43,600		43,600			3
4	Laundry	27,785	3,838		31,623		31,623		31,623			4
5	Heat and Other Utilities			33,250	33,250	225	33,475		33,475			5
6	Maintenance	6,600	5,754	18,420	30,774		30,774	589	31,363			6
7	Other (specify):*											7
8	TOTAL General Services	154,434	62,459	56,162	273,055	1,838	274,893	459	275,352			8
	B. Health Care and Programs											
9	Medical Director			1,500	1,500		1,500		1,500			9
10	Nursing and Medical Records	455,927	10,354	9,637	475,918	(4,007)	471,911		471,911			10
10a	Therapy	16,301		4,709	21,010		21,010		21,010			10a
11	Activities	14,108	622	2,160	16,890	(216)	16,674		16,674			11
12	Social Services	18,861		2,160	21,021		21,021		21,021			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	505,197	10,976	20,166	536,339	(4,223)	532,116		532,116			16
	C. General Administration											
17	Administrative	33,325			33,325	30,737	64,062		64,062			17
18	Directors Fees											18
19	Professional Services			105,716	105,716	(56,510)	49,206	(41,105)	8,101			19
20	Dues, Fees, Subscriptions & Promotions			11,603	11,603	97	11,700	(3,315)	8,385			20
21	Clerical & General Office Expenses	24,043	2,532	3,174	29,749	15,085	44,834	(100)	44,734			21
22	Employee Benefits & Payroll Taxes			129,774	129,774	7,722	137,496		137,496			22
23	Inservice Training & Education			578	578		578		578			23
24	Travel and Seminar			2,506	2,506	81	2,587		2,587			24
25	Other Admin. Staff Transportation					819	819		819			25
26	Insurance-Prop.Liab.Malpractice			27,620	27,620	599	28,219		28,219			26
27	Other (specify):*											27
28	TOTAL General Administration	57,368	2,532	280,971	340,871	(1,370)	339,501	(44,520)	294,981			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	716,999	75,967	357,299	1,150,265	(3,755)	1,146,510	(44,061)	1,102,449			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number

SENIOR MANOR NURSING CENTER

#0027359

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,654	15,654	852	16,506	6,122	22,628			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes					475	475	10,887	11,362			33
34	Rent-Facility & Grounds					2,428	2,428		2,428			34
35	Rent-Equipment & Vehicles			1,002	1,002		1,002		1,002			35
36	Other (specify):*											36
37	TOTAL Ownership			16,656	16,656	3,755	20,411	17,009	37,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,360	15,575	32,935		32,935		32,935			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,303	32,303		32,303		32,303			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		17,360	47,878	65,238		65,238		65,238			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	716,999	93,327	421,833	1,232,159		1,232,159	(27,052)	1,205,107			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number SENIOR MANOR NURSING CENTER

0027359

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,821	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(130)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,121)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	395			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 1,865		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(28,917)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (28,917)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (27,052)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 SENIOR MANOR NURSING CENTER

Page 5A

ID# 0027359
 Report Period Beginning: 01/01/2001
 Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	LINE 29 DETAIL OF OTHER ELIMINATIONS	\$	1
2	IHCA-PAC DUES	(94)	20 2
3	CHAMBER OF COMMERCE DUES	(100)	20 3
4	DEFERRED PAINTING SCHXIX-H	589	6 4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	395	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SENIOR MANOR NURSING CENTER

0027359

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(130)	0	0	0	0	0	0	0	0	0	0	(130)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	589	0	0	0	0	0	0	0	0	0	0	589	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	459	0	0	0	0	0	0	0	0	0	0	459	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(41,105)	0	0	0	0	0	0	0	0	0	(41,105)	19
20	Fees, Subscriptions & Promotions	(3,315)	0	0	0	0	0	0	0	0	0	0	(3,315)	20
21	Clerical & General Office Expenses	(100)	0	0	0	0	0	0	0	0	0	0	(100)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,415)	(41,105)	0	0	0	0	0	0	0	0	0	(44,520)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,956)	(41,105)	0	0	0	0	0	0	0	0	0	(44,061)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		CANTERBURY MANOR NURSING HOME	WATERLOO	JAMESTOWN MGT	CARBONDALE	NURSING HOME
		FAIR ACRES NURSING HOME	DUQUION	CORP.		MANAGEMENT
		FAIRVIEW NURSING CENTER	DUQUION			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	19 MANAGEMENT FEES	\$ 97,780	JAMESTOWN MANAGEMENT CORP	32.00%	\$ 56,675	\$ (41,105)
2	V	33 REAL ESTATE TAXES		FOURTH STREET LAND TRUST	100.00%	10,887	10,887
3	V	30 DEPRECIATION		FOURTH STREET LAND TRUST	100.00%	1,301	1,301
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 97,780			\$ 68,863	\$ * (28,917)

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
1	OWNERS COMPENSATION HAS BEEN								\$		1
2	ELIMINATED PRIOR TO THE COST REPORT										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SENIOR MANOR NURSING CENTER # 0027359 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization JAMESTOWN MANAGEMENT CORP
 Street Address 1001 E MAIN BLDG 4A
 City / State / Zip Code CARBONDALE, IL 62901
 Phone Number (618)549-8331
 Fax Number (618)549-0133

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158	\$ 8,066	\$	1,670	\$ 742	1
2	5	UTILITIES	HOURS OF SERVICE	18,158	2,451		1,670	225	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440	334,264	334,264	960	30,737	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158	1,795		1,670	165	4
5	20	LICENSE AND DUES	HOURS OF SERVICE	18,158	1,053		1,670	97	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718	128,698	128,698	710	11,839	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158	19,240		1,670	1,770	7
8	22	EMPLOYEE BENEFITS	HOURS OF SERVICE	18,158	63,567		1,670	5,846	8
9	24	SEMINARS	HOURS OF SERVICE	10,440	877		960	81	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440	8,910		960	819	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158	6,513		1,670	599	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158	9,267		1,670	852	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158	5,160		1,670	475	13
14	34	RENT	HOURS OF SERVICE	18,158	26,400		1,670	2,428	14
15									15
16									16
17		*** EXCESS SALARY OF RELATED INDIVIDUAL HAS BEEN							17
18		ELIMINATED PRIOR TO COST REPORT							18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 616,261	\$ 462,962		\$ 56,675	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	NONE						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **SENIOR MANOR NURSING CENTER**# **0027359** Report Period Beginning: **01/01/2001** Ending: **12/31/2001****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2000 report.		\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	10,887	2
3. Under or (over) accrual (line 2 minus line 1).		\$	10,887	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	10,887	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	10,586	8	
	1997	10,496	9	
	1998	10,533	10	
	1999	10,743	11	
	2000	10,887	12	
***** LINE 7 DOES NOT INCLUDE THE JAMESTOWN MANAGEMENT ALLOCATION				
FROM PG 8 SCH VIII OF \$475. TO RECONCILE REAL ESTATE TAX EXPENSE ADD				
LINE 7 \$10887 TO JAMESTOWN ALLOCATION OF \$475 = 11362 THIS IS THE AMOUNT				
ON PAGE 4 LINE 33.				
		FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SENIOR MANOR NURSING CENTER COUNTY RANDOLPH

FACILITY IDPH LICENSE NUMBER 0027359

CONTACT PERSON REGARDING THIS REPORT ROGER BAGLEY

TELEPHONE (618)549-8331 FAX #: (618)549-0133

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>19-148-012-00</u>	<u>225/868/ LOT 1 FOURTH STREET S</u>	\$ <u>10,761.16</u>	\$ <u>10,761.16</u>
2. <u>19-148-013-00</u>	<u>489/963/ 489/965 lot 2 4th street s/d</u>	\$ <u>125.96</u>	\$ <u>125.96</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>10,887.12</u></u>	\$ <u><u>10,887.12</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

12,936

B.

General Construction Type:

Exterior

MASONRY

Frame

concrete & wood

Number of Stories

1

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☐ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BUILDING	30,000	1970	\$ 6,000	1
2					2
3	TOTALS	30,000		\$ 6,000	3

Facility Name & ID Number SENIOR MANOR NURSING CENTER

0027359

Report Period Beginning:

01/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1970	1970	\$ 153,542	\$	30	\$		\$ 153,542	4
5	16		1976	1976	51,431		25	1,035	1,035	51,431	5
6			1976	1976	38,320		15			38,320	6
7			1976	1976	7,820		20			7,820	7
8			1976	1976	45,187		25	916	916	45,187	8
Improvement Type**											
9		FULLY DEPR(HEAT & AIR COND/NURSES STATION)		1976	30,444		10			30,444	9
10		STORAGE BUILDING		1981	1,317		15			1,317	10
11		ROOF		1982	8,430		10			8,430	11
12		ACTIVITY ROOM		1986	21,751	1,208	20	1,088	(120)	16,864	12
13		CONCRETE PORCH AND WALK		1988	3,276	218	20	164	(54)	2,214	13
14		BATH & KITCHEN TILE		1989	4,377	292	20	219	(73)	2,737	14
15		REPAIR SHOWERS		1989	548	37	20	27	(10)	338	15
16		4 WALL A/C UNITS		1990	4,893		10			4,893	16
17		PLUMBING		1990	4,324	137	20	216	79	2,484	17
18		PARKING LOT		1990	9,280	619	15	619		7,118	18
19		CUBICLE TRACK		1990	1,750		10			1,750	19
20		ELECTRICAL WIRING & FIXTURES		1990	963		20	48	48	552	20
21		ROOF		1991	14,388		20	719	719	7,191	21
22		PHONE SYSTEM		1991	3,243		20	162	162	1,701	22
23		ASPHALT WORK		1991	2,155	144	15	144		1,512	23
24		OFFICE REMODELING		1991	2,541	169	15	169		1,775	24
25		LANDSCAPING		1991	1,548	103	10	76	(27)	1,548	25
26		MORTON BUILDING		1992	1,992	199	20	100	(99)	950	26
27		FIRE ALARM SYSTEM		1994	3,345	335	10	335		2,512	27
28		PARKING LOT		1994	5,655	377	15	377		2,828	28
29		WATER HEATER		1996	1,680	112	15	112		616	29
30		WALL UNIT HEAT / COOL		1996	915		10	92	92	506	30
31		ARMSTRONG FLOORING IN DINNING ROOM		1997	4,976	332	10	498	166	2,241	31
32		NEW GASLINE RAN		1997	945	38	25	38		171	32
33		FIRE EXTINGUISHING SYSTEM ABOVE HOOD		1997	1,578	105	15	105		473	33
34		built cabinets, closet, & computer station in beauty shop area		1997	4,511	451	10	451		2,030	34
35		NEW FLOORING IN ROOM 102		1997	749	75	10	75		337	35
36		BACKFLOW PREVENTOR ON WATER SOFTNER		1997	601	40	15	40		180	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	1 WALL UNIT HEAT / COOL	1997	\$ 924	\$	10	\$ 92	\$ 92	\$ 414		37
38	CARPETING AND WALLPAPER DOWN HALLWAYS	1998	6,904	862	10	690	(172)	2,415		38
39	WATER HEATER	1998	3,291	411	10	329	(82)	1,152		39
40	2 GE THRU WALL HEAT / AC UNITS	1998	1,807	226	10	181	(45)	633		40
41	WATER HEATER	1998	3,484	435	10	348	(87)	1,218		41
42	WATER SOFTNER	1998	1,400	175	10	140	(35)	490		42
43	ROOF REPAIR	1999	8,452		10	845	845	2,113		43
44	SIGN	1999	1,392	139	10	139		348		44
45	SEAL & STRIPE PARKING LOT	1999	1,036	130	8	130		325		45
46	CARRIER A / C UNIT	1999	2,900	290	10	290		725		46
47	new carpet, added interior window, built work top, & clinical	1999	7,602	760	10	760		1,900		47
48	record storage, built water heater surround wall all in									48
49	nurses office/station									49
50	labor & materials for new sink, flooring, and lighting in	1999	1,164	116	10	116		290		50
51	priv pay room									51
52	tore out existing wood floor, laid tile on concrete, and	1999	4,683	468	10	468		1,170		52
53	wallpapered in the kozy knook & dining room									53
54	remove wallpaper, repaired walls, cut off door, new cove	1999	376	38	10	38		95		54
55	base all in the administrator's office									55
56	LIGHT FIXTURES PUT DOWN HALLWAYS	1999	435	44	10	44		110		56
57	TILE & COVE BASE IN KOZY KNOOK	2000	1,729	173	10	173		259		57
58	remove & replace damaged asphalt in parking lot	2001	1,900	63	8	119	56	119		58
59	remove & replace old vinyl perimeter of dining room	2001	1,735	87	10	87		87		59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 489,689	\$ 9,408		\$ 12,814	\$ 3,406	\$ 415,875		70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 79,467	\$ 4,205	\$ 7,801	\$ 3,596	various	\$ 53,424	71
72	Current Year Purchases	13,779	2,041	1,161	(880)	various	1,161	72
73	Fully Depreciated Assets	120,601				various	120,601	73
74								74
75	TOTALS	\$ 213,847	\$ 6,246	\$ 8,962	\$ 2,716		\$ 175,186	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	JAMESTOWN ALLOCATION			\$	\$ 852	\$ 852	\$		\$ 2,296	76
77										77
78										78
79										79
80	TOTALS			\$	\$ 852	\$ 852	\$		\$ 2,296	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 709,536	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,506	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,628	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,122	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 593,357	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 1,002 Description: DISHWASHER (828) STORAGE (174)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning
 Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u> </u> /2002	\$ <u> </u>
13.	<u> </u> /2003	\$ <u> </u>
14.	<u> </u> /2004	\$ <u> </u>

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary. <u>we only hire trained aides</u>	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39/3	hrs	\$	85	\$ 5,640	\$	85	\$ 5,640	1		
2	Licensed Speech and Language Development Therapist	39/3	hrs		30	2,458		30	2,458	2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist	39/3;39/2	hrs		95	6,367	56	95	6,423	4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy	39/2	# of prescripts				10,741		10,741	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Exceptional Care Program									12		
13	oxygen, tube feeding, medical supplies Other (specify): lab & ambulance	39/2 39/3				1,110	6,563		7,673	13		
14	TOTAL			\$	210	\$ 15,575	\$ 17,360	210	\$ 32,935	14		

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 42,470	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	180,608		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	6,513		5
6	Prepaid Insurance	(843)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 228,748	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	130,358		15
16	Equipment, at Historical Cost	131,050		16
17	Accumulated Depreciation (book methods)	(189,727)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 71,681	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 300,429	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 17,805	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	27,231		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,149		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	loan from owners	135,000		36
37	401K LIABILITY	4,153		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 193,338	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 193,338	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 107,091	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 300,429	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 119,868	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 119,868	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(12,777)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (12,777)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 107,091	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,160,483	1
2	Discounts and Allowances for all Levels	31,057	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,191,540	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	25,190	6
7	Oxygen	939	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 26,129	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,681	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,681	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	32	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,219,382	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	273,055	31
32	Health Care	536,339	32
33	General Administration	340,871	33
B. Capital Expense			
34	Ownership	16,656	34
C. Ancillary Expense			
35	Special Cost Centers	32,935	35
36	Provider Participation Fee	32,303	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,232,159	40
41	Income before Income Taxes (line 30 minus line 40)**	(12,777)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (12,777)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **SENIOR MANOR NURSING CENTER**# **0027359**Report Period Beginning: **01/01/2001**

Ending:

12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,892	2,080	\$ 38,290	\$ 18.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,906	1,975	30,088	15.23	3
4	Licensed Practical Nurses	9,287	9,992	124,799	12.49	4
5	Nurse Aides & Orderlies	27,733	30,307	262,750	8.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,702	1,853	16,301	8.80	8
9	Activity Director	1,589	1,669	14,108	8.45	9
10	Activity Assistants					10
11	Social Service Workers	1,758	1,960	18,861	9.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,204	2,360	22,343	9.47	14
15	Cook Helpers/Assistants	7,760	8,267	59,356	7.18	15
16	Dishwashers					16
17	Maintenance Workers	719	719	6,600	9.18	17
18	Housekeepers	4,679	5,051	38,350	7.59	18
19	Laundry	3,069	3,181	27,785	8.73	19
20	Administrator	1,860	2,080	33,325	16.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,182	2,285	24,043	10.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,340	73,779	\$ 716,999 *	\$ 9.72	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	100	\$ 4,492	1/3	35
36	Medical Director		1,500	9/3	36
37	Medical Records Consultant	12	350	10/3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	600	10/3	39
40	Physical Therapy Consultant	74	4,414	10A/3	40
41	Occupational Therapy Consultant	1	10	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	285	10A/3	43
44	Activity Consultant	42	2,160	11/3	44
45	Social Service Consultant	42	2,160	12/3	45
46	Other(specify) <u>DENTAL</u>	8	250	10/3	46
47	<u>PURCHASING CONSULTANT</u>		751	19/3	47
48	<u>BILLING SERVICE</u>		885	19/3	48
49	TOTAL (lines 35 - 48)	331	\$ 17,857		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	18	503	10/3	51
52	Nurse Aides	474	7,934	10/3	52
53	TOTAL (lines 50 - 52)	492	\$ 8,437		53

Ending: 12/31/2001

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINTING	1995	\$ 4,781	3	\$ 796	\$	\$	\$	\$	\$	\$	\$	\$
2	PAINTING	1999	1,768	3		295	589	589	295				
3													
4													
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17													
18													
19													
20	TOTALS		\$ 6,549		\$ 796	\$ 295	\$ 589	\$ 589	\$ 295	\$	\$	\$	\$

Facility Name & ID Number **SENIOR MANOR NURSING CENTER**

STATE OF ILLINOIS

0027359

Report Period Beginning: **01/01/2001**

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Ending: **12/31/2001**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA 1181
- (3) Did the nursing home make political contributions or payments to a political action organization? YES, IHCA-PAC If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 8 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 32,303
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,876 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

SENIOR MANOR NURSING CENTER INC.
 RECL FOR PGS 3&4 COLUMN 5 DPA COST REPORT
 12/31/2001
 ID #0027359

LINE #	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
22	EMPLOYEE BENEFITS	1876	
2	FOOD PURCHASES		1876
	RECL EMPLOYEE MEALS		
10	NURSING & MEDICAL RECORDS	661	
3	HOUSEKEEPING		661
	RECL SOAP & SHAMPOO		
21	CLERICAL & GENERAL OFFICE EXP	1476	
10	NURSING & MEDICAL RECORDS		1476
	RECL OFFICE SUPPLIES		
2	FOOD PURCHASES	216	
11	ACTIVITIES		216
	RECL FOOD USED IN ACTIVITIES		
2	FOOD PURCHASES	3192	
10	NURSING & MEDICAL RECORDS		3192
	RECL FOOD SUPPLEMENTS		
VARIOUS	VARIOUS LINE ITEMS	56675	
19	PROFESSIONAL SERVICES		56675
	FOR BREAKDOWN SEE SCHVIII		